School District of Bruce

Authorization for Medication Administration

Prescription Medication

Student Name:_____ Date of Birth:_____ Grade/Teacher:_____

TO BE COMPLETED BY MEDICAL PROVIDER

Medication Information & Instructions

Medication Name: _____

☐Tablet/Capsule ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Dose & Instructions:_____

_____

☐ Use throughout school year 20____- 20____ **OR** ☐ Start date_____ End date _____

Reason for medication: _____

For Inhaled Medication and EpiPens Only:

This student may carry and self-administer this medication at school: ☐Yes ☐No

Medical Provider Signature & Information

The health care provider whose signature follows hereby authorized school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that non-licensed, trained personnel may give the medication/treatment and the provider gives the reason why the medication/treatment must be given during the day. The student per section 118.291 (Wis. Stats.) may carry prescription inhalers with written signature from the health care provider and the student's parent/legal representative.

_____ _____ _____

Provider signature and title | Print ordering provider name | Date

_____ _____

Address | Phone Number

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Signature

The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the school district, its employees or persons who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school and school events. I give my permission for the school district to contact the health care provider listed above with any questions regarding the medication/treatment.

_____ _____ _____

Parent/Guardian Signature | Relationship to student | Date